DEPARTMENT OF AGING & ADULT SERVICES

CHOICE, INDEPENDENCE AND QUALITY OF LIFE

COUNTY OF SAN BERNARDINO
HUMAN SERVICES

OFFICE OF PUBLIC GUARDIAN-CONSERVATOR
222 West Brookside Avenue • Redlands, CA 92373-4606
(909) 798-8500 • Fax (909) 798-8575

COLLEEN KRYGIER
Director
Public Guardian-Conservator

Dear Sirs/Madams:

Thank you for bringing to our attention a matter involving a neighbor, relative, or client, which may require the services of the Public Guardian Office. This packet is being provided to best enable you to share with us your concerns. Please return the completed form so we can begin our investigation. If you are unable to complete any part of the form, please provide a written explanation.

Your cooperation in providing as much information as possible is important in order to help us conduct a thorough investigation.

If you have any questions or wish to discuss your particular matter further, please contact our Probate Investigations Unit or me at (909) 798-8500. Thank you.

Sincerely,

Public Guardian/Conservator

By: *Patricia Johnson*

PATRICIA JOHNSON
Chief Deputy Public Guardian/Conservator

Enclosure

PJ:vr

SAN BERNARDINO COUNTY PUBLIC GUARDIAN OFFICE

Before filling out the application for an investigation for public probate conservatorship, please read the following information:

LEGAL CRITERIA: Inability to properly provide for food, clothing, shelter, or physical health (conservatorship of the person) and/or substantial inability to manage financial resources, or resist fraud, or undue influence (conservatorship of the estate). The individual's incapacity must be measured and confirmed by the attending physician.

GUIDING MANDATES: A conservatorship is not an emergency response instrument. It may require as much as 8-12 weeks from the beginning of an investigation, to an actual court date. Additionally, legislation contemplates that a public probate conservatorship be the last resort and that all alternatives to such conservatorship be explored first. A public probate conservatorship may not be appropriate as a preventative measure. Generally an individual must meet the legal criteria at the time the referral is made.

I. FACTORS WHICH GENERALLY FAVOR A PUBLIC PROBATE CONSERVATORSHIP

A. The inability to think logically or exercise sound judgment. This is important when considering if the individual can provide for his/her own care and well being.

1. Examples:
    a. If multiple physical treatments are necessary and the individual lacks the ability to perceive: basic concepts of self care, diagnosis, options or treatment available; and is unable to give informed consent.
    b. Severe memory loss resulting in the individual's being unable to discern whether his/her needs are being met such as payment for housing, meals, clothing, medications, etc.
    c. Inability to choose an appropriate responsible individual to act on his/her behalf.

B. A primary physical diagnosis which might also affect mental functioning such as stroke, Alzheimer's disease, etc. **OR** a primary physical disabling disease with a secondary mental impairment which does not require mental health treatment.

C. No family members are able to provide care or act a conservator.

II. FACTORS WHICH GENERALLY DISCOURAGE A PUBLIC PROBATE CONSERVATORSHIP:

A. The individual has the ability to provide for and choose his/her own services (e.g. a person is in a nursing home, is alert and able to execute a power of attorney).

B. A second party (e.g. friend family member, facility) is providing for all of the individual's needs.

C. The individual has a primary diagnosis of mental illness or alcoholism which requires placement in a locked treatment facility.

D. The individual presents a continual resistance to assistance (e.g. able to physically resist initial placement, willing and able to walk out of treatment or placement, able to articulate and justify reasons he/she objects to a conservatorship).

E. Conservatorship is desired simply to facilitate medical consent or to pay bills.

F. The individual is 'on the streets.' The Public Guardian cannot adequately conduct an investigation unless the individual is in some type of placement such as a hospital, home, facility, etc.

REFERRAL FOR INVESTIGATION FOR PUBLIC PROBATE CONSERVATORSHIP

INSTRUCTIONS

I. FACE SHEET (Page 1)

1. Please fill our all personal information as completely as possible.

2. Relatives and Interested Parties – This should include names of any persons who have personal or professional connections to the proposed conservatee.

II. INCOME AND ASSETS (Page 2)

1. Please give as much detailed information as possible regarding finances of the proposed conservatee.

2. Item 2 refers to Supplemental Security Income (SSI) which is administered by Social Security Administration.

III. DESCRIPTION OF CURRENT PROBLEMS AND LEVEL OF FUNCTIONING (Pages 3, 4, and 5)

1. It is important that the referring party fully describe all known problems and circumstances associated with the proposed conservatee's incapacity, precipitating events, needs not being met, and level of care needed. Please be specific and use examples.

2. Be sure to sign the bottom of page 5.

IV. CAPACITY DECLARATION – CONSERVATORSHIP (Judicial Form GC-355)

1. California Law requires that the court find deficits in mental functioning of the proposed conservatee before specific powers (i.e. authority to give medical consent, contract, execute a trust or make a conveyance) can be granted to the conservator.

2. **This declaration must be filled out and signed by the attending physician.**

IMPORTANT – The document requiring physician input is necessary to satisfy legal requirements. If it is not filled out completely and singed by the physician, then the referral packet may be returned to the referring party.

County of San Bernardino
Public Guardian – Conservator
222 West Brookside Ave.
Redlands, Ca 92373-4606

REFERRAL FOR AN INVESTIGATION FOR PROBATE CONSERVATORSHIP

Name _____ AKA's _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow
Spouse's Name/Address _____

Date of Birth _____ Birth Place _____

Height (Approx) _____ Weight (approx) _____

Currently: ☐ Hospital ☐ Nursing Home ☐ Board & Care ☐ Home ☐ Other

Address & Phone: _____

Social Security # _____ Medi-Cal # _____

Medicare # _____ Citizen: ☐ Yes ☐ No Alien# _____

Veteran's Status: ☐ Yes ☐ No Service # _____ Dates of Service: _____

RELATIVES AND INTERESTED PARTIES

Name	Relationship	Address	Phone	Age

Physician's Name and Address _____

Prescription Medications (Please do not list 'over the counter' medication)

INCOME AND ASSETS

1. SOCIAL SECURITY ☐ Yes ☐ No Amount: _____
2. SSI ☐ Yes ☐ No Amount: _____ VA ☐ Yes ☐ No Amount: _____
3. WAGES ☐ Yes ☐ No Employer: _____ Amount: _____
4. OTHER INCOME/ASSETS: _____
5. CHECKING ACCOUNT ☐ Yes ☐ No Balance: _____
   Bank/Branch/Account #: _____
   Direct Deposits: _____
6. SAVINGS ACCOUNT ☐ Yes ☐ No Balance: _____
   Bank/Branch/Account #: _____
   Bank/Branch/Account #: _____
   Direct Deposits: _____
   Type of Account (Trust, etc.): _____
7. SAFETY DEPOSIT BOX ☐ Yes ☐ No Location: _____
8. STOCK/BONDS/SECURITIES ☐ Yes ☐ No Type/Location: _____
9. PENSION ☐ Yes ☐ No Annuities ☐ Yes ☐ No
   Name & address of company: _____
10. REAL PROPERTY Address: _____ Value: _____
11. MOBILE HOME Address: _____ Value: _____
12. VEHICLES Location: _____ Description & Value: _____
13. PERSONAL PROPERTY ☐ Yes ☐ No
    Description & Location: _____
14. INSURANCE POLICIES ☐ Yes ☐ No Type: _____ Company: _____
15. BURIAL PLANS ☐ Yes ☐ No Pre-Paid ☐ Arrangements: _____
16. BURIAL PLOT/CRYPT ☐ Yes ☐ No Pre-Paid ☐ Location: _____
17. WILL ☐ Yes ☐ No Location: _____
18. POWER OF ATTORNEY OR TRUST ☐ Yes ☐ No Name: _____

List any additional information Below

ASSESSMENT OF SOCIAL/MEDICAL NEEDS

It is important for our evaluation to include the following information. All referrals must address each area and be complete, if known. Skilled nursing facilities and hospital staff should be able to address all areas.

1. Is individual in a coma or has a terminal condition? _____

   (Life-sustaining devices used) _____

2. Orientation to person, place, time (be specific). _____

   _____

3. Individual's knowledge of medical condition and medication. _____

   _____

4. If individual is in pain, to what degree? _____

   _____

5. Social and communication abilities. _____

   _____

6. Ability to follow instructions. _____

   _____

7. Ability to make needs known. _____

   _____

8. Grooming and eating abilities. _____

   _____

9. Bladder/bowel control and frequency. _____

   _____

10. Mobility and aides used. _____

    _____

11. Ability to transfer from bed to wheelchair (If applicable). _____

    _____

12. Ability to cooperate with treatment and/or assistance (specify). _____

    _____

    _____

    _____

ASSESSMENT OF SOCIAL/MEDICAL NEEDS, continued

13. Who secured current placement? _____

_____

14. Monthly expenses and amounts (if known). _____

_____

15. Where is the income mailed? _____

_____

16. Prior address (if currently in acute hospital). _____

_____

17. Does individual have any past or current history of violence, verbal, or physical aggression or acting out behaviors? If yes, please describe in detail.

_____

_____

_____

18. (Optional) Pertinent personal history. _____

_____

Continue to next page.

Please check all areas of need that are not currently being met. Describe precipitating event(s) that led to this referral, and level of care required.

1. NEEDS NOT BEING MET:

☐ Food ☐ Clothing ☐ Shelter ☐ Health ☐ Finances

2. EVENTS LEADING UP TO THIS REFERRAL AND HOW NEEDS ARE NOT BEING MET:

3. LEVEL OF CARE NEEDED:

Signature of Referring Party	Date	Agency and Title
Printed Name		Phone Number

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:	*FOR COURT USE ONLY*
— TELEPHONE NO.: FAX NO. *(Optional)*: E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	
CAPACITY DECLARATION—CONSERVATORSHIP	CASE NUMBER

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER

The purpose of this form is to enable the court to determine whether the (proposed) conservatee *(check all that apply)*:

A. ☐ is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for *(date)*: ☐. *(Complete item 5, sign, and file page 1 of this form.)*

B. ☐ has the capacity to give informed consent to medical treatment. *(Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)*

C. ☐ has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. *(Complete items 6 and 8 of this form and form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and form GC-335A.)*

(If more than one item is checked above, sign the last applicable page of this form or form GC-335A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-335A if item C is checked.)

COMPLETE ITEMS 1–4 OF THIS FORM IN ALL CASES.

GENERAL INFORMATION

1. *(Name)*:
2. *(Office address and telephone number)*:

3. I am
   a. ☐ a California licensed ☐ physician ☐ psychologist acting within the scope of my licensure ☐ with at least two years' experience in diagnosing dementia.
   b. ☐ an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. *(Religious practitioner may make the determination under item 5 ONLY.)*
4. (Proposed) conservatee *(name)*:
   a. I last saw the (proposed) conservatee on *(date)*:
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continuing treatment.

ABILITY TO ATTEND COURT HEARING

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. *(Complete a or b.)*
   a. ☐ The proposed conservatee is able to attend the court hearing.
   b. ☐ Because of medical inability, the proposed conservatee is NOT able to attend the court hearing *(check all items below that apply)*
      (1) ☐ on the date set *(see date in box in item A above)*.
      (2) ☐ for the foreseeable future.
      (3) ☐ until *(date)*:
      (4) **Supporting facts** *(State facts in the space below or check this box ☐ and state the facts in Attachment 5)*:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 [Rev. January 1, 2004]

Probate Code, §§ 811, 813, 1801, 1825, 1881, 1910, 2356.5

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

Note to practitioner: This form is ***not*** a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6A–6C): *Check the appropriate designation as follows:* ***a*** *= no apparent impairment;* ***b*** *= moderate impairment;* ***c*** *= major impairment;* ***d*** *= so impaired as to be incapable of being assessed;* ***e*** *= I have no opinion.)*

A. **Alertness and attention**

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Orientation (types of orientation impaired)
a ☐ b ☐ c ☐ d ☐ e ☐ Person
a ☐ b ☐ c ☐ d ☐ e ☐ Time (day, date, month, season, year)
a ☐ b ☐ c ☐ d ☐ e ☐ Place (address, town, state)
a ☐ b ☐ c ☐ d ☐ e ☐ Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
a ☐ b ☐ c ☐ d ☐ e ☐

B. **Information processing.** Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)
i. Short-term memory a ☐ b ☐ c ☐ d ☐ e ☐
ii Long-term memory a ☐ b ☐ c ☐ d ☐ e ☐
iii Immediate recall a ☐ b ☐ c ☐ d ☐ e ☐

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
a ☐ b ☐ c ☐ d ☐ e ☐

(5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
a ☐ b ☐ c ☐ d ☐ e ☐

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
a ☐ b ☐ c ☐ d ☐ e ☐

(7) Reason logically.
a ☐ b ☐ c ☐ d ☐ e ☐

C. **Thought disorders**

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Hallucinations (auditory, visual, olfactory)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).
a ☐ b ☐ c ☐ d ☐ e ☐

(Continued on next page)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. *(continued)*

D. **Ability to modulate mood and affect.** The (proposed) conservatee ☐ has ☐ does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. *(If so, complete remainder of item 6D.)* ☐ I have no opinion.

***(Instructions for item 6D:** Check the degree of impairment of each inappropriate mood state (if any) as follows: **a** = mildly inappropriate; **b** = moderately inappropriate; **c** = severely inappropriate.)*

Anger	a ☐	b ☐	c ☐	Euphoria	a ☐	b ☐	c ☐	Helplessness	a ☐	b ☐	c ☐
Anxiety	a ☐	b ☐	c ☐	Depression	a ☐	b ☐	c ☐	Apathy	a ☐	b ☐	c ☐
Fear	a ☐	b ☐	c ☐	Hopelessness	a ☐	b ☐	c ☐	Indifference	a ☐	b ☐	c ☐
Panic	a ☐	b ☐	c ☐	Despair	a ☐	b ☐	c ☐				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

(1) ☐ do NOT vary substantially in frequency, severity, or duration.
(2) ☐ do vary substantially in frequency, severity, or duration *(explain; continue on Attachment 6E if necessary)*:

F. ☐ *(Optional)* Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is ☐ stated below ☐ stated in Attachment 6F.

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

a. ☐ has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.

b. ☐ lacks the capacity to give informed consent to any form of medical treatment because he or she is ***either*** (1) unable to respond knowingly and intelligently regarding medical treatment ***or*** (2) unable to participate in a treatment decision by means of a rational thought process, ***or both.*** The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: _____.)

8. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

_____ _____

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

ATTACHMENT TO FORM GC-335, *CAPACITY DECLARATION—CONSERVATORSHIP,* ONLY FOR (PROPOSED) CONSERVATEE WITH DEMENTIA

9. It is my opinion that the (proposed) conservatee ☐ HAS ☐ does NOT have dementia as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders.*

   a. ☐ **Placement of (proposed) conservatee.** *(If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)–9a(5).)*

      (1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because *(state reasons; continue on Attachment 9a(1) if necessary):*

      (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include *(describe; continue on Attachment 9a(2) if necessary):*

      (3) ☐ The (proposed) conservatee HAS capacity to give informed consent to this placement.

      (4) ☐ The (proposed) conservatee does NOT have capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of his or her actions with regard to giving informed consent to placement in a restricted and secure environment.

      (5) A locked or secured-perimeter facility ☐ is ☐ is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.

   b. ☐ **Administration of dementia medications.** *(If the (proposed) conservatee requires administration of psychotropic medications appropriate to the care of dementia, please complete items 9b(1)–9b(5).)*

      (1) The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of dementia, for the reasons stated in item 9b(5) *(list medications; continue on Attachment 9b(1) if necessary):*

      (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include *(describe; continue on Attachment 9b(2) if necessary):*

      (3) ☐ The (proposed) conservatee HAS capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia.

      (4) ☐ The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate his or her actions with regard to giving informed consent to the administration of psychotropic medications for the treatment of dementia.

      (5) The (proposed) conservatee needs or would benefit from the administration of the psychotropic medications listed in item 9b(1) because *(state reasons; continue on Attachment 9b(5) if necessary):*

10. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME) ▶ (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335A [New January 1, 2004]

DEMENTIA ATTACHMENT TO
CAPACITY DECLARATION—CONSERVATORSHIP

Probate Code, § 2356.5

American LegalNet, Inc.
www.USCourtForms.com